FLORIDA NETWORK OF YOUTH AND FAMILY SERVICES
EXEMPT REVIEW ADDENDUM

Program Name: BEACH House
Program Type: CINS/FINS
Provider Name: Stewart-Marchman ACT Behavioral Healthcare
Location: Volusia County / Circuit 7
Original Review Date(s): December 7-8, 2010
Exempt Review Date: January 19, 2012

QA Program Code: 167
Contract Number: V4P01
Number of Beds/Slots: 6
Lead Reviewer Code: N/A

Review Team

The Florida Network of Youth and Family Services (FNYFS) and Florida Department of Juvenile Justice (DJJ) wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Keith D. Carr, Lead Reviewer/Consultant Forefront LLC/Florida Network of Youth and Family Services
Ashley Davies, Review Specialist, DJJ Bureau of Quality Improvement
Kristi Castenda, Director of Program Support , Boys Town of Central Florida, Inc.
S. Martin Reid, Operations Management Consultant, DJJ Office of Prevention and Victim Services

Summary

This review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures).

The Stewart-Marchman ACT Behavioral Healthcare– Bringing Enrichment And Children's Home (B.E.A.C.H.) Children in Need of Services/Families in Need of Services (CINS/FINS) program achieved deemed status in December 2010. On January 19, 2012, a team comprised of representatives from the Florida Network of Youth and Family Services, DJJ Bureau of Quality Improvement and DJJ Office of Prevention and Victim Services conducted a deemed site visit.

The BEACH House CINS/FINS residential program services all of Volusia and Flagler Counties and other surrounding counties. The agency's residential program continues to experience consistent moderate to high occupancy on a consistent basis. According to FNYFS data extracts the agency's residential and non-residential service programs are primarily serving youth and families that reside in 32110, 32114, 32117, 32129, 32137, 32164, 32174, 32720, 32738 and 32763.

Program Update

The agency reports that there are two (2) vacancies at the time of this program review. These vacancies include 1 full-time Male Direct Care Worker position and 1 part-time Non-residential position. The agency utilizes students enrolled in local universities to perform specific tasks such as treatment plans, phones and screenings. The agency has also hired a licensed therapist and a Psychiatric ARNP in other divisions within the company.

The agency conducts drugs screens onsite on youth admitted to the youth shelter on an as needed basis.

The agency has increased its outreach efforts. These efforts include making United Way posters; Hosting a 5 Kilometer Run that raised approximately $10,000; conducting a Youth to Military Service Letter writing campaign; and conducting Community Groups on campus.

The agency reported that is has implemented training for staff that focuses on de-escalation of conflict that occurs in the shelter. The agency is also developing a plan to provide Domestic Violence training. The agency is also working towards increasing its efforts to provide additional Substance Abuse Prevention Activities and variety of Group-centered activities.

The agency operates several other programs for both youth and adults. The agency reports that it has recently begun providing services to first-time offenders. In addition, the agency reports that they have recently secured the Basic Center Grant.

The agency has an Adolescent Advisory committee. The agency also reported on the status of its Adolescent Advisory Committee and its Community-Based Advisory Board.

The agency conducts an audit/inspection of all of its major programs. This process includes a full onsite inspection that includes a safety and security walk through. The agency reported that two (2) Air Conditioned Handlers were purchased since the last compliance monitoring review. The agency began preparing all of its own meals last year. The agency now prepares all meals three (3) times per day and all snacks in between meals.

The agency reports that it has been working directly with Kurt Hudson at the Florida Network office which has led them to be able to meet the 180-Day Follow Up requirement. This had been an area that they had been struggling to meet on a consistent basis.

The agency also confirms that it has submitted both the annual training plan and disaster plan. As of the date of this review, no staff members have reported being arrested since the last on site program review.

Exempt Review Findings

This Exempt review included the review of Standard 1 Management Accountability – 1.01 Background Screening, 1.02 Abuse free Environment, 2.01 Screening and Intake, 2.03 Case/Service Plan, 2.04 Case Management and Service Delivery, 3.01 Shelter Care

Requirements, 3.03 Suicide Prevention, 3.04 Medications, 3.05 Medical/Mental Health Alert Process.

The team reviewed eighteen (18) youth files (15 open and 3 closed) and other miscellaneous documents. The team also observed all common areas of the youth shelter, the medication storage area, safety equipment (knife-for-life, first aid kits, wire cutters, fire alarm system and camera surveillance), as well as the shelter sleep areas, dining room, bathrooms, chemical storage and shelter perimeter area, staff interviews, youth interviews and interactions between the staff and the youth. The SMA-ACT – Children in Need of Services/Families in Need of Services (CINS/FINS) program achieved deemed status in December 20120. On January 19, 2012, a team comprised of representatives from the Florida Network or Youth and Family Services, the DJJ Bureau of Quality Improvement and DJJ Office of Prevention and Victim Services conducted a deemed site visit. This Exempt review included the review of Standard 1 Management Accountability – 1.01 Background Screening, 2.01 Screening and Intake, 2.03 Case/Service Plan, 2.04 Case Management and Service Delivery, 3.01 Shelter Care Requirements, 3.03 Suicide Prevention, 3.04 Medications, 3.05 Medical/Mental Health Alert Process.

Standard 1.01

A review of the agency's policy and procedures for case plans and reviews was reviewed and was found to be inclusive of all components required by Standard 1.01. The agency had four (4) background screenings conducted since the last DJJ Quality Assurance review was completed in January 2011. A total of 4 personnel records were reviewed to ensure that background screening clearance requirements were met by this agency. Of these files, three (3) out of 4 staff/personnel files reviewed onsite were screened according to departmental policy. The agency had one (1) personnel file that started with the agency as an intern and was later hired as a full-time employee. The date of the DJJ background screening clearance date occurred after the intern's official date of hire as an employee. Further, two (2) employee files had multiple hire dates listed after the original date cleared by the DJJ background screening unit. The hire dates seem confusing given that the original background screening information. The source of the confusing originates from the agency's lack of clarification of actual hire and transfer dates given that these 2 employees remained within the agency the entire time and only moved into other positions within the agency. It is recommended that the Program Director inform and reinforce DJJ background requirements within the agency's Human Resource Department to ensure consistent compliance with the DJJ-1800 background screening policy. At the time of the onsite review, the agency was informed that a total of four (4) employees have upcoming 5 year rescreens that are due by their 2012 anniversary dates.

Standard 1.02

A review of the agency's policy and procedures for case plans and reviews was conducted and was found to be inclusive of all components required by Standard 1.02. A total of three (3) youth resident surveys and three (3) staff member surveys were conducted and reviewed to assess the agency's adherence to this standard. Overall, survey results indicate that the program consistently met all requirements of the indicator without exception for staff members. One (1) of the 3 staff members did not indicate that notifying the mental health authority as notification

step if a youth expresses suicidal thoughts. In addition, survey results indicate that the program consistently met all requirements of the indicator without exception for youth admitted to the shelter. One (1) youth survey indicated that they rated the mental health and substance abuse services they received by the program as poor; 1 youth rated the grievance process as poor; and 1 youth stated that they were not informed on what to do in case of a fire.

The overwhelming opinions documented by youth surveyed indicate that the program received Acceptable responses on almost all questions on the survey. Youth commented specifically on how helpful staff members have during their shelter stay.

Standard 2.01

A review of the agency's policy and procedures for screening and intake was conducted and was found to be inclusive of all components required by Standard 2.01. A total of three (3) open residential client files were reviewed to determine the agency's adherence to this standard. All 3 files reviewed met the requirements for this standard and met the 7-day eligibility screening requirement upon being referred. Each resident receives a Client Handbook that informs the recipient of the orientation process, client rights, grievance procedures, 24 hour access to service, admission release criteria, intake and assessment process, services offered, client responsibilities release of information and . Additional documents included CINS/FINS Shelter voluntary placement agreement, anti-bullying pledge, parent handbook, authorization for services with informed consent, youth prevention services values, parent brochure and orientation checklist.

Standard 2.03

A review of the agency's policy and procedures for case plans and reviews was conducted and was found to be inclusive of all components required by Standard 2.03. A total of three (3) residential and three (3) non-residential files were reviewed the agency's adherence to this standard. The case plans in all 3 of the residential files met all indicator requirements for this standard. The needs and goals were indentified in accordance with the psycho-social assessment and screening tools, date of plan, type, frequency and location of service, person responsible, target dates, actual completion dates and the majority of required signatures were documented. One (1) residential file contained an actual date of goal completion with status C, when it should have been an A for achieved. Further, there was one service plan that did not have a parent/guardian signature. All other service plans included the required component.

The case plans in all 3 of the non-residential files met all of the aforementioned indicator requirements for this standard. Specifically, the case plans in all 3 of the residential files met all indicator requirements for this standard. The needs and goals were indentified in accordance with the psycho-social assessment and screening tools, date of plan, type, frequency and location of service, person responsible, target dates, actual completion dates and the majority of required signatures were documented. Other exception-related findings noted include an error in the actual date that goals 1 and 2 were completed. Another file was missing a supervisor's signature the service plan. In 2 of the 3 files reviewed, a youth and parent signature was missing on one of the plan reviews. Per policy, if a youth and/or family signatures are missing,

documentation of why would be found in the SAN's record file. This practice was inconsistent in these 2 files. All other case files had evidence of youth and parent signatures, as well as 30 day plan reviews. Goals for both residential and non-residential are comprehensive and address issues revealed in the screening and assessment phases for all 6 files.

The 180-Day follow up folder was reviewed. Compliance with NETMIS was reviewed as well. The agency has improved in this area. During the entrance conference the agency reported that they are using a new internal tracking process to improve compliance requirements in this area.

Standard 2.04

A review of the agency's policy and procedures for case plans and reviews was assessed and was found to be inclusive of all components required by Standard 2.04. The policy does not mention referral needs and coordination of referral(s). A total of six (6) files were reviewed (3 residential and 3 non-residential) for the completion of case management and service delivery requirements. The same files reviewed in 2.03 were reviewed for compliance related to this standard. Of these files, all contained documentation to satisfy the performance standards. Each file possessed evidence of the referral being issued solely based on need. One case was not applicable. All case files contain documentation that supports service plan implementation, monitors youth and family's progress reports and updates, general support to families, documented referrals to case staffing committee when applicable, evidence of judicial intervention when applicable, evidence of recommending appropriate additional services, case monitoring reviews and court orders and termination with the required 180-day follow up. Non-residential case files with case staffings demonstrated that the counselor was involved as well as youth and families. There was evidence of documented case staffing notes and recommendations and addendums made to service plans, with appropriate signatures. Overall, the agency displayed good case staffing documentation and addendum for recommendations. Additionally, progress of youth and families is documented in the SANS section.

Standard 3.03

A review of the agency's policy and procedures for suicide prevention was reviewed and was found to be inclusive of all components required by Standard 3.03. A total of three (3) open residential files were reviewed to determine the agency's adherence to this standard.
The agency Program Director who is a masters level staff member oversees and reviews all major screening and assessment information utilized to determine each youth's mental health status during the screening and assessment phases of the admission process and throughout the duration of their shelter stay. The agency also has access to licensed staff members with in other divisions of the agency to assist with medical, mental health and suicide risk related issues for all youth served in their CINS/FINS youth shelter and non-residential programs.

Both residential and non-residential suicide policies were comprehensive, contained all suicide prevention components required and were approved by the Florida Network of Youth and Family Services during Summer 2011. This policy does not require that the agency utilize a licensed staff member to review and oversee the suicide prevention process. The agency sends all youth that indicate meeting imminent danger status due to meeting the suicide risk screening criteria to the local Baker ACT receiving facility name Halifax Behavioral Services.

A total of 3 residential client files were reviewed to determine the agency's adherence with the suicide risk requirements. All 3 files reviewed were screened as required. All 3 files had completed CINS/FINS Intake Assessments. The agency completes an evaluation of suicide risk among adolescents on each youth admitted to the shelter. However, each of the documents is signed by a staff member, but not reviewed or signed by a supervisor. All youth that screen and receive a positive indication of suicide risk are placed on sight and sound. The agency had 1 case demonstrating evidence of close observation counts. The remaining cases were Baker Acts and each of these had evidence of these youth being escorted by the agency to the local mental health facility. The agency has recently hired a licensed staff person to review suicide screenings.

Standard 3.04

A review of the agency's policy and procedures for medication was assessed and was found to be inclusive of all components required by Standard 3.04. A total of three (3) closed files were reviewed to assess the agency's medication practice and ability to meet the requirements for this standard. All topical and oral medications are also stored in a medicine cabinet in the direct care staff work station. Controlled substances/medications are stored in a locked box inside a locked medication cabinet. There is a refrigerator in the medical closet for any medication requiring refrigeration. Shift-to-shift counts are documented for all controlled substances. At the time of this onsite review, the shelter had two (2) controlled substances onsite and shift-to-shift inventories were documented for both medications, as well as perpetual inventories when the medication is given. The shift leader on each shift is delineated to have access to secured medications during that shift. Sharps and syringes are secured in a locked drawer in the medical closet and are inventoried weekly. Over the counter medications are inventoried by maintaining a perpetual inventory and also inventories weekly.

Three (3) youth files were reviewed for medication administration. In all 3 youth files the medication administration record documented the youth's name, DOB, allergies, medication side effects, a picture of the youth, staff initials and youth initial when the medication was given, and the full printed name, title and signature and each staff who initials a dosage was documented on the medication record. There was also a full printed name and signature of the youth receiving the medication. This program does not currently have a nurse or other licensed medical professional(s) related for the provision medications or other medical/health services assigned to this program.

Standard 3.05

A review of the agency's policy and procedures for Medical/Mental Health Alert Process was assessed and was found to be inclusive of all components required by Standard 3.05. A total of three (3) closed files were reviewed to assess the agency's alert process/practice and ability to meet the requirements for this standard. The youth shelter has a color-coded mental health and medical alert system in place. The applicable color-coded dot is placed next to the youths name on the alert board in the medical closet and the staff office. The alert board in the medical closet and the staff member's office. The alert board in the medical room also documents all youth on medications plus any youth's allergies. A shift review is done each shift that documents all youth on medications and then lists each youth separately and documents the

medications the youth is on, any medical concerns, allergies, appointments and the youth's behavior for the day. All 3 files reviewed documented all applicable alerts were appropriately documented in the shelters alert system.

Findings

As a result of this onsite Exempt review, the review team determined that the program:

☒ **would** receive an overall program performance rating of at least Satisfactory on a regular review. Accordingly, the program **RETAINS EXEMPT STATUS**.

☐ **would not** receive an overall program performance rating of at least Acceptable on a regular review. Accordingly, **EXEMPT STATUS IS REVOKED**, and a regular review will be conducted within 90 days.